Le Bénédicité

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About our cover . . .

Le Bénédicité (Grace before Meat), by Jean Baptiste Siméon Chardin. Fourth of a series of Journal covers on family life . . . reproduced with the permission of the Louvre and the Metropolitan Museum of Art.

THE JOURNAL OF SOCIAL HYGIENE

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POWER PLUS IDEALS

"Defenders of Freedom" is the official slogan for Armed Forces Day, approved by President Truman for observance Saturday, May 19, by the military services and the public. The theme, announced by Secretary of Defense Marshall, is two-fold:

- ☆ A tribute to our Armed Forces as an integral and interdependent part of the total material and spiritual power of America now being mobilized.
- ☆ A renewal of faith in our country's sacred heritage —the ideals of peace and freedom to whose preservation our power is dedicated.

This is the second unified "day," which was established last year in place of the separate dates previously observed by the Army, Navy, Marine Corps and Air Force. As in 1950, the emphasis is on a rounded community-level observance. The keynote is cooperation.

Troops and military equipment will take part in as many community programs as possible, and the Armed Forces will, if possible, authorize the participation of naval vessels, aircraft and airborne troops. Reserves will join in the observance, and State Governors may ask National Guard units to participate. Where practicable, military installations will hold "open house."

In response to the request of the Department of Defense that national organizations tell their members and affiliate groups about the plans for Armed Forces Day and urge their participation, ASHA takes pride and pleasure in passing this invitation along to you and hopes that you will join in observing this important event.

Each of us, whether in mufti or uniform, is a "defender of freedom" when we lend our aid and interest at such a time, and none knows better than the social hygiene worker that ideals must be kept bright by renewed faith and translated into action by power well used.

SOCIAL HYGIENE IN THE ARMED FORCES

by Major General John M. Devine

Health, as you are well aware, is a primary factor in national strength and consequently is of the utmost importance in national security. The military man, second only to the doctor, is deeply concerned with all matters that affect the health of our people. The rigors of war can be borne only by the strong body, and any disease that undermines that strength diminishes by an equal amount our capacity to defend ourselves.

In 1947, a committee headed by Dr. Karl Compton, then president of MIT, made a very penetrating and comprehensive study of national security. After analyzing the problem and studying it in detail, the committee concluded that the first requirement is "a strong, healthy, educated people." I believe every thinking person will agree with this conclusion. It is not in our armaments, our machines and our training camps that our real strength lies, but in the people themselves, in their physical, mental and spiritual vigor.

The Armed Forces have always been interested in the health and welfare of their individual members, particularly in that field with which social hygiene deals. From the very nature of military life the danger of social diseases increases as large numbers of men, separated from home and family, are assembled in camps often

An address February 20, 1951, at the New York Tuberculosis and Health Association's annual conference.

isolated from adequate facilities for healthful recreation. Particularly now, in a national emergency, with increasing numbers of men being called up, with the population displacement resulting from the need for workers in the armaments industry, with greater numbers of women working in all fields, the problem is an important one and deserves our best thought.

I assure you the Armed Forces are aware of their responsibilities and have, I believe, an understanding of the problem and its difficulties as well as a sound approach to a solution.

Strictly speaking, we have no definitely defined social hygiene program as such. There are, however, several correlated programs that may be considered to constitute a program of social hygiene. Such a program encompasses far more than the control of venereal diseases. It includes all those elements that tend to elevate the moral and social plane of a military unit, particularly the establishment of sound athletic and recreation programs. It includes the encouragement of hobbies, the provision of wholesome social activities, opportunities for education. In fact, it includes a continuing and aggressive effort to provide the serviceman with healthful outlets for his spare-time activities and to elevate the social and moral tone of all of them.

Too often in considering the problem of the control of venereal diseases we adopt the negative approach, both in civilian and in military life. We think of police measures, of the closing of houses of prostitution or placing them off limits. We think of curing the diseases after they have been contracted. Such an approach used to be common in the Armed Forces, but the attitude toward the problem has changed materially in the past few years.

Let me outline for you what might be called the evolution of the present social hygiene program. It has developed over a period of several years.

It has long been the policy of the Armed Forces to endeavor to repress prostitution. Regulations published periodically have clearly outlined the accepted attitude.

"The repression of prostitution," Army regulations state, "is an established policy of the Department of the Army in its program for the welfare of personnel, the development and guidance of character, and the control of venereal disease."

No deviation from this policy is authorized, and the policy applies in overseas commands as well as in the United States. Houses of prostitution are off limits for all military personnel, and disciplinary action will be taken against any who enter.

The other services have similar regulations. While they differ in wording and sometimes are capable of varying interpretation, the

intent is the same. The Armed Forces consider the toleration of prostitution as "socially objectionable, potentially destructive of public decency, and productive of immorality and disease."

Services and Civilian Agencies Cooperate

The first cooperative effort between the services was the publication of a directive in August, 1944, establishing what were at that time called the Joint Army-Navy Disciplinary Control Boards. In November, 1950, these were reconstituted as the present Armed Forces Disciplinary Control Boards. These boards consist of eight official members, two from each of the services—Army, Navy, Coast Guard and Air Force. Each service is represented by a senior officer from its provost marshal's office (or its counterpart) and a senior officer from its surgeon's office.

The functions of the board are to consider reports on conditions, within the area of its jurisdiction, relating to improper discipline, prostitution, venereal disease, liquor violations, disorders and other undesirable conditions, as they apply to service personnel. Whereas these same functions were previously carried out separately by the several services, they are now combined.

Meanwhile, in November, 1948, another important step had been taken to unify the efforts of all those agencies concerned with the handling of the problem of VD. An eight-point agreement was reached designed to coordinate the activities of state and local health and law enforcement officers in cooperation with the Public Health Service of the Federal Security Agency. It was signed by the Secretary of Defense for the Armed Forces, by the Secretary of the Treasury for the Coast Guard, by the Federal Security Administrator for the Public Health Service, and by the president of the Association of State and Territorial Health Officers.

Cooperation with the Armed Forces was through the Armed Forces Disciplinary Control Boards. One of the most significant points in the program was, by the way, to invite the assistance of the American Social Hygiene Association, affiliated social hygiene societies and other official and voluntary welfare organizations. The help of these organizations has been beyond price.

There is at least one AFDC Board in each Army area and as many subordinate ones as the situation requires. These boards meet regularly and function about as follows:

The representatives of the discipline or police branches present to the board data and information regarding matters pertaining to improper discipline, liquor violations, disorder, etc. The medical representatives present reports on venereal disease, illness that has

been traced to improper sanitation of eating establishments and, often indirectly, prostitution.

Representatives of civil health, police and social organizations also attend meetings for the purpose of coordinating venereal disease data and for imparting information regarding the effectiveness of contact-reporting and case-finding. Practically all boards take advantage of the services of the American Social Hygiene Association. District representatives of ASHA endeavor to attend as many of the meetings of the various boards in their districts as possible. They also provide studies relative to commercialized prostitution, studies whose value can hardly be overestimated.

In general, the AFDC Boards get a pretty complete picture of the situation in their area of responsibility, with civilian and military police officers, medical and public health officers, and the American Social Hygiene Association each contributing important information to the group as a whole.

It should be mentioned, too, that the United States Brewers Foundation cooperates actively with the AFDC Boards in their endeavor to maintain a high standard of discipline and order. This foundation is concerned with the promotion of law observance and the maintenance of wholesome conditions in retail beer outlets frequented by members of the Armed Forces. On their part, this is a matter of good public relations, but it is also a very helpful effort. While the foundation has no police power over the owners of taverns or bars, its influence is quite great, and its voice is usually listened to with respect.

Similarly, representatives of local and state liquor distributors associations meet from time to time with the various boards, usually by invitation, to discuss means of controlling the sale of liquor to minors and the problem of pimps and hustlers in bars and taverns. While the majority of these organizations also have no police power, they do wield a big stick in that they have considerable control over who is licensed and who is not.

All actions of the AFDC Board, while they are necessary, are nevertheless negative in their approach to the problem. They do a pretty good job in handling a situation which already exists, but they do not attack the problem at the bottom.

During the years 1947 to 1950, the attitude of the military toward the VD problem was changing. We were beginning to realize that the problem is not simply the prevention or cure of a disease. The Disciplinary Control Boards which include only policemen and doctors are all right as far as they go, but they are not a complete solution to the problem. A sounder approach was necessary, because the problem essentially is a moral one.

The Army's character guidance program, initiated in 1948, constituted such an approach. The idea back of this program was to develop high standards of personal conduct, to teach moral responsibility and self-discipline, to raise the general behavior level of military units, and to extend into the military service as far as practicable the good influences of the home, the church and the school. In short, it was designed to establish high standards of personal and group behavior and to maintain a wholesome, healthful and moral climate in which the serviceman can live and move.

The implementation of such a program requires far more than police and medical personnel. The Character Guidance Councils include in their sphere of interest all the activities of the soldier, particularly those activities which in themselves are not strictly military. The off-duty hours are the ones of greatest significance in maintaining such a program. The chaplain is of vital importance both as a spiritual adviser and as a counselor. The special services officer, with his facilities for recreational and social activities, plays an important part. The information and education officer, with the opportunities he has to offer for self-improvement, is an active participant.

Above all, however, it is the commander whose efforts will determine the degree of success in achieving the aims of the program. Character guidance is a command responsibility. It involves leadership, example and the best possible program of supervised recreation. It means a continuing effort to encourage voluntary participation in healthful off-duty activities.

Nearly every large post has adequate facilities to satisfy the most demanding young man. The efficient commander must be able to coordinate successfully all the means at his disposal to encourage participation in such activities and to see to it that the atmosphere at all of them is a wholesome one and that standards of behavior and language are such that he will be proud of them.

This is a sound approach to social hygiene. In the discussion of the character guidance program, it should be noted, there is no direct reference to VD. It was true that at the first meetings of the initial Character Guidance Councils the tendency was to think only of VD, its prevention and cure. Gradually, however, the idea has taken root that Character Guidance Councils are concerned not only with police and medical aspects, but with the whole problem of providing a wholesome, active and socially satisfying life for the service-

man. Such councils must work constantly to eliminate the bad influences which tend to undermine character and to encourage everything which contributes to establishing high standards of behavior.

Character Guidance Councils are interested in housing, in recreational and athletic facilities. They are interested in adequate supervised social activities, both on and off the base. They are interested in encouraging thrift through savings bonds, and also in encouraging participation in the education program.

They are interested in the attitude of nearby communities toward servicemen and in the attitude of servicemen toward the communities. They are interested in behavior on the base, in the mess halls and theatres, in the service clubs, in neighboring towns. They are concerned with the general atmosphere at social gatherings of all sorts. In short, they are interested in establishing a wholesome atmosphere at every service activity.

Individuals coming into the Armed Forces are the product of their environment. They bring with them their own attitudes and their own standards. It would be really wonderful if those attitudes were sound and the standards high. If they are not, it is our intention to do our best to make them so.

The accomplishment of such a task is not easy, and I am not prepared to say how successful it has been so far. That it has succeeded to some degree, there can be no doubt. And I am sure that results in the future will be increasingly gratifying.

Good times in good company help to build good character.

The attitude of the Armed Forces toward social hygiene is, I am sure, a sound one. With the rapid increase in the size of our Army, Navy and Air Force and the prospect of a long period of preparedness, it is important that this should be so. We have a responsibility to the country, and we are making an honest effort to meet it.

Civilian agencies have been a very great help indeed. The American Social Hygiene Association, welfare organizations, local police and health organizations all are cooperative. Their continued cooperation is, of course, essential.

I will go a little farther than this, however, and say that what is really needed is the complete cooperation of all the communities in the country, particularly those in the vicinity of camps. When a soldier or a sailor or an airman goes to town, he should be accepted for what he is: a young American in town for a change of scenery or a little diversion. He should neither be pampered as a hero nor looked at askance as a probable source of trouble. He should be made to feel just as much at home and accepted in the same manner as anybody else.

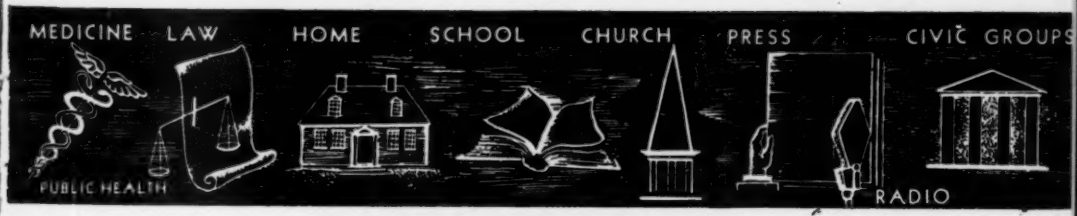
That is all, and it is not asking very much. It implies an acceptance on the part of the public of the fact that sailors are people, that the behavior standards of airmen are about average for young men their age and that the percentage of soldiers out on a binge is about the same as for any other group. In short, the general public should expect from the Armed Forces about the same conduct they expect from their own neighbors.

Certainly that element of all communities which caters to the baser instincts of men merely because they are in uniform should be, and can be, stamped out.

In summary, let me say that the Armed Forces in the present emergency take social hygiene very seriously. We realize our responsibilities and will endeavor to meet them. Our approach is sound, but implementation is difficult. It will require the sympathetic understanding and cooperation of the people of the country if it is to succeed.

The citizen of this nation must come to look upon the sailor, the airman and the soldier as citizens also, and accept them as such. Perhaps they might even go a little farther and take an interest in their welfare, and especially in the welfare of the young ones.

Communities might even go so far as to set up their own Character Guidance Councils to look after all the young people of the neighborhood, including visiting servicemen. Then the social hygiene problem in the Armed Forces would be as close to a solution as it is ever likely to come.



COMMUNITY RESPONSIBILITY IN FAMILY LIFE

by Judson T. Landis

In our culture there is often an observable difference between what people say they believe and what they do in practice. This inconsistency is apparent in family life. We believe in and laud family stability. We acknowledge that a stable family is necessary for the emotional development of children. We are critical of nations that have done anything to destroy a stable family life. But our nation has led the world in family disorganization.

Our divorce rate for years has been higher than that in most other countries of the world. It is estimated that in America there are between 1,500,000 and 2,000,000 children under 18 years of age whose homes have been broken by divorce. In 1870, the ratio of marriages to divorces was 34 to one; in 1900, 12 to one; in 1940, five to one; and in 1950, it was four to one.

To understand the increase in family disorganization in the United States, we must look at some of the socio-economic changes which have had as great an impact upon the family as the impact of radio upon communication.

In general, as pointed out by Professors Burgess and Locke, the family is in transition from an institution to a companionship. In the past, the important factors unifying the family were external, formal and authoritarian, as the law, the mores, public opinion, tradition, the authority of the family head, rigid discipline and elaborate ritual. At present, in the emerging form of the companionship family, the unity inheres less and less in community pressures and more and more in such interpersonal relationships as the mutual affection, the sympathetic understanding and the comradeship of family members.

Such social changes as the following now make it more difficult than ever for couples to maintain stable families: development of urban civilization, work centered outside the home, great mobility of

population, transition in the roles of men and women, change in attitudes toward divorce and ease in divorcing.

Most leaders are agreed that the community should do something to help people establish marriages which will be permanent and homes in which children will find happiness. There is agreement on the general principle that instead of permitting young people to drift into marriage and parenthood we should substitute careful preparation for marriage and parenthood.

There is not agreement on some points concerning the family life education program; communities differ about the details of methods and materials. It is important, then, for leaders to get together and to map out programs of action on the points on which they do agree, rather than to let the whole program be held up while time is spent quibbling over minor differences. There is enough work to be done in the major areas where we agree.

Agencies planning programs to better family life must recognize that at present there are already many forces in the community preparing young people for marriage and family living. While we debate methods and materials, these forces go ahead giving doubtful and frequently dangerous preparation for marriage to our young people.

In the average community, the movies, newspapers, magazines, comic books, radio serials, popular songs and television furnish young people with much of their information on sex and marriage. A careful analysis of many of these "family life programs" would show that in most respects the information is false and misleading and presents a point of view opposite from the facts as revealed in research on what makes for successful marriage.

To illustrate, the theme of the average movie or magazine love story is sudden love, love as the one important factor, short acquaintance, "and they lived happily ever after." Research reveals a far different picture: growing in love; love as only one factor among many important ones; love can mature into married happiness only if the couple have many other things in common; longer acquaintances and engagements are better; and marriage means two people begin to learn to live with each other.

In setting up a community education program, we need first to assay our present community programs, the forces both negative and positive that are educating young people for marriage. It will be impossible for us to do away with the escapist type of movies, the undesirable literature, the comics and the radio and television programs that may be giving the wrong kind of preparation for marriage. But a part of a positive educational program in any community is to recognize that such forces are strong in the educating

of youth and to seek to counteract their effect by presenting realistic pictures of love and marriage. True, love as seen in the movies is often a pleasant escape into fantasy, but it may have no relation to the facts of love and marriage in real life.

The Church and Family Life Education

In general, churches should have a more aggressive program of family life education than they have at present. Scientific research of successful marriage supports the teachings on family life of most of the major religious groups. Research shows that people who are church members have more stable families. Those who have a church wedding have a lower divorce rate. Those given sex information in the home have happier marriages. Those who marry someone within the same faith have a lower divorce rate; agreement on religion is predictive of greater happiness in marriage.

Churches can do much to help family members at each stage of development. Active youth groups can help make it possible for young people to date, court and marry within the faith. Classes in preparation for marriage taught by the minister or some other qualified leader can help youth make more stable and happier marriages.

If the minister is qualified, he can often act as family counselor for his members. In fact, most ministers of necessity do much of this type of counseling, whether or not they are qualified. Churches can become family-centered churches.

Churches that do not feel that it is the place of the schools to give sex information must accept the responsibility for giving parents instruction so that they are more willing and able to give such information to their children.

As we look to the future, we may hope that seminaries will do more to train young ministers in the general field of marriage and family living and family counseling. The minister is in a key position to exercise leadership in family life education, but at present many ministers hesitate to accept that leadership. A few seminaries are now endeavoring to train ministers in marriage and the family. This tendency is increasing in seminaries.

The Physician and Family Life Education

People who have great confidence in their doctor are inclined to go to him for counsel on marital and personal problems. The doctor is almost forced to serve as counselor, whether or not he is qualified to do so. In the past, medical schools have done little to train their students for marriage and family counseling. Doctors have been forced to learn this part of their work through experience.

Because of their specialized training in the biological functioning of the body, doctors are the logical ones to help out in this phase of family life education. But unless the doctor has taken special interest in and qualified himself for counseling on other types of marriage problems he should, if possible, refer the patient to someone in the community who does have such training. Medical schools are now recognizing this lack in their training program, and many have set up courses of study better to qualify future doctors for dealing with the emotional problems of people.

A recently completed study of 212 couples who had gone through their first pregnancy emphasized the need for giving a broader training in medical schools so that the doctor would have a better understanding of the effects of social-cultural conditioning upon the psychosomatic behavior of the patient. In the study, all of the wives were asked this question, "How could your doctor have been of more service during pregnancy and childbirth?" The following comments were typical:

- "My doctor was really too busy to find much time to talk to me. It would have helped to be able to talk things over with him."
- "The office visits were too rushed . . . gave the feeling of being on an assembly line."
- "I was certain I would die after my first visit to my doctor."
- "I felt a lack of interest on his part. Many times I wanted to talk to him but couldn't due to lack of time."
- "If only he had explained why and what would happen, how the child is born, the muscles that contract, when to relax and when to start helping and what was about to happen in the delivery room."
- "My doctor could have helped me so I wouldn't have been so afraid. I told him I was afraid. All he said was that there is nothing to be afraid of."

The average girl enters her first pregnancy filled with fears because of old wives' tales, folklore and misinformation, and she needs help to overcome her fear of the unknown. A relatively innocent remark, such as "You are small," when the doctor makes the pelvic examination may have an impact the doctor does not suspect. The young woman may interpret it to mean that she will have a very difficult time and probably die in labor.

We should say that there was the highest praise from the young wives for those doctors who had bothered to take time to give them

a clear understanding of their own biology, of foetal development and of what happens during childbirth.

After going through the first pregnancy, 17.5% of the wives indicated they wanted fewer children than they had wanted before and only three percent wanted more children. Forty percent feared another pregnancy and childbirth.

Could doctors in the community help in making the childbirth experience less traumatic? If not, what agency in the community should help with this important part of family life education?

Welfare Agencies, Social Workers and Community Health Agencies

The largest and most generally available family counseling service in our country is provided through member agencies of the Family Service Association of America. There are approximately 300 member agencies in all parts of the country, and most of these do family counseling. At present, there seems to be the feeling in some communities that the family agency is for the lower socio-economic levels only or for welfare clients. Therefore, this agency needs to do a better selling job of its services to all members of the community.

Counselors need a broad training so that they can deal effectively with all phases of family maladjustment, not only with family problems of an economic nature. As soon as possible, counselors should attempt to qualify as members of the American Association of Marriage Counselors. Schools of social work can do more in their graduate training programs to fit social workers for marriage counseling.

Welfare agencies might well evaluate their community programs to see whether they are adequate in providing for the leisure time and social activities of the aged; whether there is proper community care for unmarried mothers; whether sufficient instruction is being provided for expectant parents.

The Schools and Family Life Preparation

Probably the greatest hope for preparing the next generation for marriage and successful parenthood lies in a carefully planned program of family life education in the schools. We might take the definition of family life education as given by the Life Adjustment Committee of the United States Office of Education. It is: "That part of a total school program which provides opportunities for acquiring the understandings, the factual knowledge, the skills and the abilities necessary for homemaking and for successful participation in family life."

Some people see family life education as training for girls in cooking and sewing. Some see it as sex education, some as parent

education and still others as family economics. A well planned and balanced program will include all phases: the biological, psychological and economic aspects of family life, household tasks, cultural changes in the family, and training for parenthood. Such a program will not give undue emphasis to any one phase of family life.

The program should be geared to meet the developmental needs of all family members in the family life cycle, from infancy to old age. In family life education there should be a strong emphasis upon the personal and social adjustment of the individual as basic to successful marriage and parenthood.

Briefly, the school program, where adequately developed, includes the following:

Elementary Program—Units of education here are centered around successful home and family living. Units of study centering around the home will be as readily accepted as units in the past dealing with Indians, transportation, etc., and they will help the child from an unhappy home to get a more normal picture of family life.

A study of family life education in the elementary schools in the 48 states made in 1949 by the National Council on Family Relations showed that 14 states had recently revised the curriculum for elementary education to give emphasis to family life. Twenty State Superintendents of Public Instruction stated that the elementary education curriculum was planned around family life.

Junior High Program—For this age group, units of study or semester courses are now being developed which place emphasis upon personal adjustment. From the eighth grade on, young people are very much concerned about their own personality development and about their social relationships with others. Since the stability of the family and the individual's success in personal relationships are largely determined by the individual's adjustment with himself, this phase of the educational program is important and needs to be given early in the teens.

Freshmen or sophomores are ready for courses or units of study called "personal adjustment," "life adjustment," "basic living." Such courses should consider boy-girl relationships, behavior on dates, personality and how it develops, steps for improving personality, understanding parents, etc.

Senior Courses in Preparation for Marriage—Some high schools now require all seniors to take a semester course in preparation for marriage and family living. Many schools have an elective course.

This course should consider the senior as an adult who is soon to marry and form the parent generation. (Too many courses consider the senior a teen-aged infant and try to help him fit into his

present family. We favor the adult approach.) The course considers personality as basic in successful marriage, problems of dating, factors to consider in selecting a mate, those elements important in successful marriage, problems of adjustment in marriage, and parent-child relationships.

Wherever possible, it is desirable to have boys and girls in this class spend time both observing and helping care for nursery and kindergarten children. With the aid of a skilled teacher, students can get a better understanding of child development as well as a perspective on their own development. Highland Park, Mich., requires all senior girls to observe in the nursery school, and half the boys do so on a voluntary basis. All seniors are required to take the class in family living.

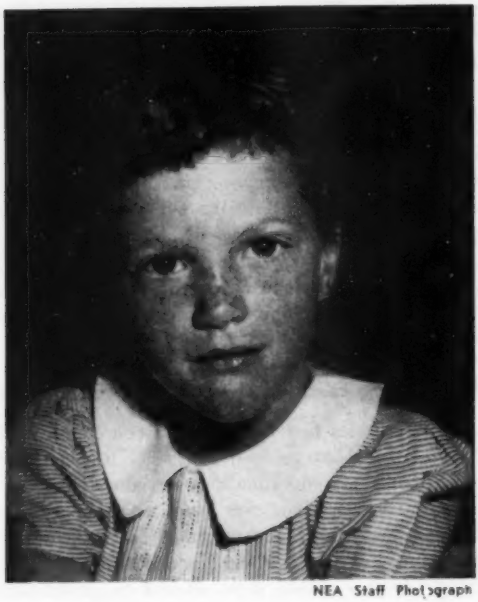
Sex and Reproduction Education a Part of Family Life Education

It is unfortunate that there is a misconception in the lay mind, and even among some professionals, when it comes to distinguishing between family life education and sex education. Sex education is not family life education. Sex education is only one part of family life education. Sex education should have its proportionate share of attention. Certainly it cannot and should not be ignored or omitted. Neither should it be allowed to predominate over other important phases . . . or to become the tail that wags the dog.

I believe that most communities are pretty well agreed that the schools should have a family life education program, but the disagreement arises in some communities over the sex education phase of the program. Strong community resistance to sex education should be respected. But it is often necessary to differentiate between real community resistance and the voices of a few cranks in the community.

Recently the editor of a "yellow journal" went to the high school library and read some of the reference books on marriage. He then published a series of articles referring to the "filth" taught in the family living classes. Students, parents, ministers and others in the community had sponsored and were back of the family living program and in an organized way they put the publisher in his place. In that community, the man trying to sell newspapers through sensationalism was not allowed to block a family life education program that had community support.

Let us then find out what our communities really think about the sex and reproduction phase of family life education. Most leaders are agreed that there should be no such thing as courses solely on sex and reproduction education. The materials should be integrated into other courses with a broader emphasis. There is also agree-



NEA Staff Photograph

Knowledge is not enough.

ment that the practice common 30 years ago of having a doctor come to the school to give a special lecture on sex to segregated boys and girls is wrong. The materials presented should ordinarily be given by regular classroom instructors who have the confidence and respect of students and parents.

In nursery school and the elementary grades, the teacher should answer the normal questions asked by children about sex and reproduction as conscientiously as she attempts to answer their other questions. She needs to take pains to *know* the right answers. Some schools find class projects such as the keeping of pets useful here, especially in urban communities.

The lower grades (4, 5, 6) are the place for the use of films such as "Human Growth" to prepare the child for understanding his biological maturing. Junior high school is too late for the showing of such films, since many children are in the midst of this new part of their development and now may be less objective and more emotional in their attitudes.

During the junior high years, it would seem that family life education should help children to understand the emotional aspects of sex and how they may cope with their own sex drives. I believe that this is the phase of the program which needs most thought.

Knowledge of the facts of sex and reproduction are not enough (although studies of young people who are the most promiscuous show that they are also those least informed on sex). Throughout our country a surprising proportion of our unwed mothers are children 14 and 15 years old. The fathers are older youths who exploit uninformed girls. A program to instruct youth on the control of the sex impulse must come earlier than many of us realize.

The biology course in high school should consider the subject of human sex anatomy and reproduction in the same thorough and objective way that it considers circulation, respiration and digestion. It is quite shocking that some high schools must cut the pages on human reproduction from the biology books before the books can be used by the students. This attitude toward reproduction forces children to get their information from unwholesome sources.

The course in preparation for marriage for seniors should deal with the biology of sex and reproduction, if this has been neglected in the biology course. Information on pregnancy, childbirth and sex adjustment in marriage should be available. A very important obligation of this course is to prepare future parents so that they will be able to do a better job with their children's sex education than their parents could do. Ideally, after a generation of this type of education in the schools, parents should be able to take over and the schools could retire from the field of sex education, which perhaps theoretically should belong in the home.

College Courses—A course in preparation for marriage is rapidly becoming a part of the general education of all college students, regardless of their field of specialization. It is now recognized that whether a student is to be an engineer, teacher or architect, he is also going to be a husband and probably a parent and he needs training for that part of his vocation. Some colleges now require all students to take a course in preparation for marriage before graduation. The usual program, however, is to offer an elective course without prerequisites.

Advanced and graduate courses are being added to train future teachers and community leaders for leadership in all areas of family life education, and many universities are offering special summer workshops for the training of leaders.

Adult Education—Classes are being organized to meet the needs of all family members. Many communities have classes for expectant parents and for parents of small children. A few communities have classes for adults in the middle years of life and for old people. The needs of older family members are being increasingly recognized.

Most communities recognize the need for parent education classes which parallel the instruction given to the children in school, and

the need for cooperation of school and parents in the establishment of the family life education program. Films and text materials used with students can also be used with parent groups. Students in family life classes can give effective programs before service clubs, PTA's and mothers' clubs, and in turn adults can be used effectively on panels in class instruction.

Detroit, Mich., now has classes in family living in all the senior high schools. As a class project, the students in different high schools take turns presenting a radio program called "Youth Looks at Life." The program is an informative one, each week discussing phases of family life.

In general, the school program on family life education has been difficult to get started because there were not adequate materials for use in the elementary and secondary schools, and there were not enough teachers qualified by personality and training to do the work. Both these problems are rapidly being solved. Many fine films have been developed or are in production for use at all levels. Texts have been written specifically for the senior classes in preparation for marriage. More materials are needed for the elementary program, but these are being written. Summer workshops make it possible for teachers to get further training.

At all levels, there seems to be acceptance of family life classes. Various evaluations by college teachers of marriage courses show that from 90 to 100% of the students strongly approve of the courses. On many campuses, courses were instituted because of student pressure for them. Teachers of family living courses at the high school senior level report the same reaction from their students. There is a general feeling among both high school and college students who have had a class in preparation for marriage that the classes should be required for all students.

Coordinating Community Efforts

In any successful community effort there must be close coordination so that all groups will be working together toward the common goal. The school needs to know what the church is doing, and the doctor needs to know what is being done by welfare agencies and by schools and churches.

In most American communities, there is a great interest in working to bring about greater stability in family life, and many agencies are working toward that goal. However, usually there is a serious need for coordination of these efforts. Other communities may well follow the lead of San Francisco, which (with an initial grant from the Rosenberg Foundation) is among the first, if not the first, city in our country to set up a Clearing Service for all community agencies interested in improving family life.

SAN DIEGO'S FAMILY FAIR

A Project to Promote Better Families

by G. Gage Wetherill, M.D.

Commercial advertising has raised the "threshold of appeal" for the average person to a level which requires similar fanfare for any subject seeking public attention and participation. Take such a program as strengthening family life, for example. How can it be presented to the people so as to appear as important and desirable for everyday use as the foods, beauty aids and household labor-saving devices so widely advertised?

In San Diego, Calif., the County Coordinating Council in 1949 decided that one answer to this question might lie in a "Family Fair" along the lines of the traditional County Fair, with all the ballyhoo and color associated with such an event. At the close of that first Family Fair, when Director Kenneth S. Beam reported an attendance of 10,000 people, the Council knew it had hit on something good, and immediately scheduled a second Family Fair for 1950, which attracted 13,500. As this is written, plans are in process for 1951, and the Fair looks like an annual event from now on.

Objectives of the Family Fair

For many years, the Council had participated in annual conferences dealing with family relations, family records, youth welfare and conferences conducted for youth by youth. These conferences became so multiple that their planning required much time and duplicated effort. Moreover, they appealed only to a limited group . . . usually the professional workers rather than the mothers and fathers and boys and girls themselves.

The Family Fair was designed to combine all these conferences into one great effort to attract both workers and families, and especially to bring in the people who would benefit most. Broadly speaking, the objective of the Fair is to strengthen family life

- By acquainting as many people as possible with the agencies, organizations and institutions working to maintain wholesome family life.
- By making available the latest and best information on practical measures to be taken by individual families to promote family health, well-being and happiness.

Where to go first?

The Fair Program

For its general theme, the 1950 Family Fair chose "Family Life at the Midcentury," and the work exhibits presented by community agencies emphasized this angle. The two-day program ran from 10 a.m. to 10 p.m. on Saturday, May 13, and from 1 p.m. to 6 p.m. on Sunday, May 14.

As one entered the 90′ x 180′ hall in the Conference Building at Balboa Park, nothing was lacking in the way of carnival appeal. The place was alive with activity. There were music, bright lights, color, people busy in a variety of ways. Together they presented especially the challenge we used to have when we went to the County Fair . . . where to go first?

Walking through the aisles formed by the 70 booths of interesting exhibits and demonstrations, one could have his hearing tested by an audiometer, select a variety of attractive health pamphlets and leaflets, see a demonstration of Braille reading and writing, or compare early family life in San Diego with that of the present day. These exhibits, which formed the heart of the Fair, told in many ways the story of how community agencies contribute to family living, and were found to attract more interest than other program features such as lectures and conferences.

Of special interest was the large exhibit shared by the Jewish, Catholic and Protestant faiths to show the importance of religion in family life, at the same time demonstrating how religious groups can work together for the common good.

The 70 exhibits, from 60 organizations, represented the following fields of work:

Child and youth-serving	16
Education	13
Health	11
Family service	7
Religion	5
Community organization	4
Law enforcement	4

Borrowing ideas from the commercial world, the exhibits were supplemented by music, dancing, movies and other "action" attention-getters.

Band concerts were scheduled throughout the day. Six free educational movies were being shown continuously. Other attractions included first-aid demonstrations by Boy Scouts, safety services and home nursing, puppeteers presenting a play, "Family Crises," in the puppet theater, American Youth Hostel bicycle parade, square dancing, a modern dance concert by college students, Mexican and Spanish dances, Hawaiian dances, folk dances, fencing demonstrations, a hobbies exhibit, a chimes recital, one-act plays, family sings, and community singing.

At the first Fair, free refreshments were served by the ladies of the Jewish, Catholic and Protestant churches, but since they prepared for 2,000 people over a period of two hours, and were swamped by over 2,600 the first 45 minutes, they did not attempt this the second year.

The Saturday evening session opened with the singing of the "Star-Spangled Banner," pledge of allegiance to the flag, invocation and a word of welcome.

Imagine, all this for the family . . . and free!

Who Goes to the Family Fair?

Children—because of the action in the demonstrations and on the stage, the music, dancing (by children), the "One-Girl Band," the puppet shows, movies and so many other things going on all at once.

Youth—because of the 13 exhibits of the youth organizations and young people actually at work or on hand to explain the activities; the demonstrations in the booths and on the central stage; and for older youth, two impressive exhibits by San Diego State College.

Parents—because of the opportunity to learn much and to ask questions regarding family health, child care, youth welfare and family relations; to see the latest movies on these subjects; and to obtain up-to-date literature.

Music, bright lights, color, people busy in a variety of ways.

New Arrivals—because of the information on recreational opportunities for the elderly (community welfare exhibit), the exhibits by the Historical Society and the opportunity to meet people from one's home state through the registration by states. Everyone was invited to register in a "State Book" indicating from which state he came to California. Every state was represented but one.

Community Leaders—because even the best informed could learn much regarding the services of many voluntary and official agencies. In two hours one could accumulate information it would ordinarily require months to assemble.

Some Fair Mechanics

The city provided the buildings and printed programs. The County Board of Supervisors provided and erected display booths for the 70 exhibits supplied by community agencies. Voting booths (12 feet wide, six feet deep and six feet high) met the requirements adequately and inexpensively.

A number of business firms provided materials and professional assistance. The promotional campaign was financed by a special projects committee and by donations from various organizations. Several hundred interested individuals donated their time and services.

Costs

The first Family Fair, attended by 10,000 people, cost $10,016. The second Family Fair with an attendance of 13,500 people cost

$1,394. The chief items of expense were printing (an attractive program was given to each visitor), publicity, corrugated fireproof paper for exhibits, labor to set up and dismantle booths, transportation, etc.

In addition to these overall items, 48 exhibitors using 61 booths or rooms reported expenses totaling $1,386, an average of $22.73 per exhibit.

Admission was free not only to the exhibits, but to all motion pictures and entertainment.

Plans for the Third Family Fair in 1951

A review of the program last year leads one to the opinion that since the event is called a Family Fair, greater emphasis should be placed upon family activities than upon the functions of community agencies. Therefore, in 1951 the agencies will be grouped on a functional basis as they contribute to family living in the following fields, with the organizations working together in coordination and planning:

- Family health (including nutrition)—Health Division of the Community Welfare Council
- Family activities (hobbies, recreation)—City Recreation Department
- Education for family life—city and county schools, San Diego State College
- Youth organizations—Youth Service Division of the Community Welfare Council
- Family religion—Council of Churches, Catholic churches, Jewish synagogues
- Solving family problems—Family and Child Welfare Division of the Community Welfare Council

Four conference sessions were held as part of the first Family Fair, but the interest in the exhibits and entertainment so far outran the conferences that it was decided not to try to combine the two in the future. It is possible that a few outstanding speakers will be invited in 1951, but they must be exceptional to compete with other attractions.

The 1951 dates (the first week of May) are planned to overlap with those of the state convention of the California Congress of Parents and Teachers so that the parent-community leaders from over the state may visit the Fair. Other communities may then take up the

idea of their own Family Fairs. It is reported that those responsible for the State Fair at Sacramento are seriously considering incorporating the Family Fair idea in their Fair this year.

Some Conclusions

Summing up, it may be said that the Family Fair does for families what the County and State Fairs do for farmers. As these events help to improve farming, the Family Fair promotes better families. Family improvement may not as yet have caught up with hog and cattle improvement, but we're on our way. The family is being re-discovered and recognized.

Perhaps the instability of world affairs is forcing us back to fundamentals for security. At any rate, there are indications that the family is beginning to regain its social importance of the past. Its strengths and weaknesses are being revealed anew, its values exposed.

It is good that the family is in for re-emphasis. Such projects as San Diego's Family Fair can help the family adapt and re-adapt as the way of life changes.

How about a Family Fair for your community?

BRAND NEW PUBLICATIONS!

A-816 In Defense of the Nation.
ASHA's annual report of problems and accomplishments in 1950. Free.

A-817 Let's Tell the Whole Story about Sex.
The speech and four scripts by Edward B. Lyman which attracted so much attention in the January Journal. 25¢ each; $2.50 per dozen; $20.00 per 100.

A-818 That Baby You Love.
Appealing folder to stimulate prenatal blood tests. For the use of Negro groups. 5¢ each; $3.50 per 100; $15 per 1,000.

BACK IN STOCK!

A-639 Human Relations Education.
A 1951 revision of the San Diego schools' popular outline for the teaching of family life units. 75p. 50¢ each.

THE BIRTH MODELS

R. L. Dickinson's Monument

Some personal notes by
Bruno Gebhard, M.D.

"The Woman as Wife and Mother" was the first special exhibit I worked out for showing in Vienna in the spring of 1928. This was part of a large traveling exhibit which the German Hygiene Museum showed in the main capitals of Europe. The president of the Austrian Republic thought so much of the exhibit that I was awarded the Orden II. Klasse des Oesterreichischen Roten Kreuzes. That was quite an honor for a young man 27 years old who had just been married and to whom the days of a delayed honeymoon in the cherry blossom-dotted villages of the Danube valley were heaven on earth.

Nearly 20 years later a much greater honor was given me. On February 13, 1945, a letter marked "Personal and Confidential" was on my desk. The first three lines gave me one of those wonderful feelings which happen perhaps only once a year:

> "Dear Dr. Gebhard:
>
> I wish I could have a heart-to-heart talk with you, for I esteem you my wisest counselor. The matter in question is the disposition of my models."

The following two paragraphs carried some typical Dickinson critical comments on persons and institutions in New York and Chicago, and the closing paragraph read:

> "Lest a man of 84 suddenly die—however well at present—I am considering a codicil to my will, leaving the models to one of the museums unless otherwise disposed of. Will you be East anytime in the near future?
>
> Yours heartily,
>
> Robert L. Dickinson, M. D."

We at the Cleveland Health Museum are proud that we acquired the 100 Dickinson sculptured models of human reproduction in 1945. We also received the sole right for manufacturing and distributing these models, which were first shown at the New York World's Fair in 1938–39 under the sponsorship of the Maternity Center Association.

From a personal standpoint, I feel that the privilege of exhibiting the models adds great satisfaction to the career I began with the showing of "The Woman as Wife and Mother" in Vienna over 20 years ago.

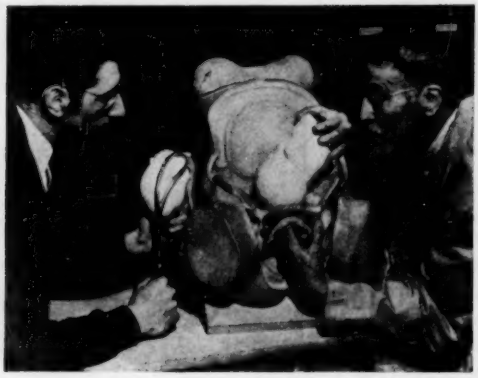
"The Rodin of Obstetrics"

Dickinson had been his own master illustrator for nearly 40 years, but he was so much aware of the advantage of the three-dimensional teaching that at the age of 78 he became the "Rodin of Obstetrics." His long-standing friendship with Malvina Hoffmann, sculptor of the "Races of Mankind" in the Chicago Museum of Natural History (Field Museum), was a great stimulant, and Abram Belskie became Dickinson's co-worker.

Dr. Dickinson started to make the birth models in order to teach students how to sew up a tear, how to deliver a baby with instruments, how "to take just four minutes to bring out the baby coming feet first," and many of the models are for professional use only.

Films and television are the fashion of the day in medical education, but there are some things only models can teach. Allan Barnes, professor of obstetrics at Ohio State University, testifies: "In my experience, no two-dimension teaching aids or mechanical models equal in instructional value these full-scale sculptures depicting the process from the beginning of labor to the delivery of the shoulders. The motion picture can adequately record the external phenomenon of delivery—restitution, external rotation, delivery of the body—but what the baby is doing before it comes within the range of the camera lens (or the obstetrician's eye) can be visualized only by serial saggital sections such as these. It is to this group of models that the students, both in medicine and in nursing, return most often for study. As far as the acceptance of the (duplicate) models by the student goes, that has been excellent . . . With reference to the durability and condition of the composition, we have given them quite a beating while transferring them from classroom to classroom and building to building and have even sent them over to a nearby high school. Through all this, we lost the toes of one of the babies."

Medical schools in the United States and Canada are using duplicates of the Dickinson models, and with the use of plastic materials the models have become more lifelike. The same is true of those countries where the nurse-midwife is taking care of the majority of deliveries. It was my pleasure last summer to address a meeting of the Royal College of Midwives at St. Guy's Hospital in London. The response was more than enthusiastic.



Abram Belskie and Dr. Dickinson work with one of the birth models.

In the so-called "undeveloped" areas of the world, these models will prove an immeasurable aid in mass training, inasmuch as pregnancy and parturition know no racial differences or national boundaries.

Many of the Dickinson models have a hidden kind of humor which will reveal itself only to the careful observer. Visitors who themselves are twins look with delight at the models demonstrating fraternal and identical twins, arranged Pullman style, in upper and lower berths, the posture of the three sets illustrating the old adage of "see, speak, hear no evil." There is also the circular plaque labeled "Birth Prelude" which shows the stages of the embryo from the first to the 10th month where the largest embryo is reclining a la Empress Josephine on a placenta while balancing a three-month-old embryo in its hand.

Dickinson was a book lover, and the rare book collection of the New York Academy of Medicine is the best witness of this. It was natural for him to design book-plates for his many friends, and his "Birth Rest" bookends have become welcome gifts to physicians from their thankful patients and friends. One bookend is solid, the embryo propped up against a pelvis, and the other is in three parts, to be used as a desk model. The baby can be passed through the pelvis to demonstrate delivery.

Since we acquired the models in 1945, duplicates have been used mainly for family life education. At the time of the opening of our museum, we had the famous "Birth Series" on display. Dr. Richard Bolt, at that time director of the Cleveland Child Health Association, had secured a grant from Congresswoman Frances P. Bolton, and had started to add classes for the so-called expectant fathers to those already established for expectant mothers.

"You'll never guess what we did today!"

In New York City, the Maternity Center Association was the pioneering organization in this field, and the "Birth Atlas" has become one of the widely used visual teaching aids.

The Clara Elizabeth Fund for Maternal Health at Flint, Mich., under David Treat, has year by year increased its activities in introducing family life classes into high schools. The Dickinson models are the backbone of the classes.

Smaller schools which cannot afford to use duplicate models are taking advantage of filmstrips, lantern slides and kodachrome slides produced in the museum's workshop. Here is what one girl wrote to another:

"Hi, Doie!

You'll never guess what we did today. I was about to enter 151 when Edna dragged me up, all the way up to 304. When I got up there I was just about exhausted and I had to sit behind Jo Ann and you know how big and tall she is. Dorothy started the slide machine.

Goodness, Doie, you never saw such interesting slides. They showed everything you could imagine. They showed a picture of the modern man and woman. Miss . . . . . mentioned how well developed they were, and they were usually tall, medium weight with good posture. It also showed pictures of the uterus at normal size, then how it stretched as the pregnant woman became bigger and how it shrunk to normal size again. Next it showed how the baby was situated while developing, then it showed the situation of twins, triplets and quintuplets.

What came next I never thought could happen. It showed the baby leaving the mother's body. Imagine a big, say 7 lb. baby, coming out of the little vagina. Then it showed the after-birth.

Well, so long, Doie! I sure hope you can see those slides.

Nancy"

Since the arrival of "Juno," the talking transparent woman, at the museum, there has been quite increased interest in our exhibits, "The Wonders of New Life," where the main models of the Dickinson collection are displayed. We have no age limit for our visitors. We prefer that children come with their parents, but very often children do come by themselves. We cannot imagine that any harm can be done this way. Children are usually more grown up than their parents like to admit. The old saying of a Danish social hygiene educator is still true: "Better let them know a year too early than a day too late."

During our first 10 years it has been quite rewarding to see the models accepted by schools, including the parochial schools, and even more significant, by the Amish people in Ohio. An increasing number of elementary children who have been properly prepared by their classroom teachers and who have the approval of their parents, use these models.

The blind study the models with their gentle hands.

Here are some testimonials from student reports written after a visit to the museum:

- "What interested me most was when you told us about the babies because I have been wanting to know about them. I didn't ask my mother and father about it because I knew they would say I was too young to know about it." (5th grader).
- "When you can actually see the things you are studying it makes a much clearer picture in your mind and also you are not apt to forget." (11th grader).
- "It is wonderful also that the 7th graders will be taught certain problems for it is at that age when they need help and if they weren't too close to their parents before they will get farther from them when they are afraid to ask about personal problems, and then resort to the advice of their friends of the same age." (12th grader).

Some of the latest creations of the Dickinson-Belskie team were "Norma" and "Norman." Harry L. Shapiro, in "Americans, Yesterday, Today, Tomorrow," has given in an entertaining way a scientific appreciation of the average American girl, 18 years old, and her 20-year-old boy friend. Norma is modeled from the recent measurements of 15,000 women from many parts of the United States and from various walks of life. Her measurements and also those of "Juno" are on display at the museum.

	Norma	*Juno*	*Venus*
Height	63½″	67¼″	64″
Bust	35½″	37¾″	38″
Waist	29″	31½″	31⅕″
Hips	39″	38½″	40⅘″

A contest, "The Search for the Living Norma," was conducted in 1945 by the Cleveland *Plain Dealer*. There were 3,863 women of all ages competing for this honor.

We are told again and again that we live in the age of science. We are likely to forget that medicine is not only science but also art. Robert L. Dickinson combined both in his person.

He was first and always a physician, which means a healer, and a doctor in its original sense, a teacher. He started work very young. He had to wait three months before he was allowed to practice medicine after passing his State Medical Board examination before he was 21 years old.

His life was not short. His artwork will be of great benefit to future generations all over the world.

DOES THE VD PAMPHLET EDUCATE?

by Beatrice G. Konheim
and Dorothy Neuhof Naiman

The teaching of hygiene in a large urban college should provide an excellent opportunity for family health education. In order to include the family in our sphere of influence, we have long made it a practice to give our students popular health pamphlets dealing with topics discussed in the classroom, hoping in this way to raise the level of health information of their parents. In an attempt to determine the effectiveness of such distribution, a study involving eight health topics, of which venereal disease was one, was undertaken. The method used was to test parent-subjects before and after a three and one-half months period during which health literature was distributed to an experimental but not to a control group.

Free pamphlets on eight health topics (listed in Table 1) were secured from private and public health agencies and insurance companies. "Questions and Answers about Syphilis and Gonorrhea," published by the American Social Hygiene Association, was the pamphlet used as the source of venereal disease information. Fifty multiple-choice questions were formulated from facts specifically stated in the pamphlets. This series of questions was administered to all subjects under controlled conditions. The subjects were given every reason to believe that this test constituted the total experiment.

In the ensuing three and a half months, however, the experimental subjects received the eight pamphlets at approximately weekly intervals, delivered to one part of the group by mail, to the other by their daughters. At the end of this period, all subjects, control as well as experimental, were retested on the same series of questions.

The following data give some indication of the type of population with which we were dealing: 57% were females; 75% had been

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* Prepared in cooperation with the Bureau of Public Health Education and the Bureau of Records and Statistics of the New York City Department of Health.

** This study was made possible by grants from the Nora and Abbie (Nooney) Scholarship Fund of Hunter College. We are also indebted to the Bureau of Social Research, Columbia University, and the Health Council of Greater New York for their assistance.

*** Konheim, Beatrice G. and Naiman, Dorothy N.: Free Health Literature—How effective is it? Research Quarterly, American Association for Health, Physical Education and Recreation. In press.

educated in English-speaking countries; 32% had had at least some college education and 44% at least some high school; in addition to the 43% who listed "housewife" as the present occupation, 20% were in professional and other upper white-collar occupations and the remaining 37% were classified as lower white-collar, semi-skilled and unskilled workers.

This population was divided into an experimental group of 165 whose daughters were enrolled in a hygiene course prescribed for freshmen, and a control group of 77 parents of freshmen who had not taken hygiene as yet. There was no statistically significant * difference between the experimental and control groups on the basis of sex, education or score on the initial test.

Results

Table 1 presents data relative to the information level of the entire population as shown by the preliminary test.

Although the series of questions on the several topics could not be equated, an effort was made to keep them of comparable caliber. It is therefore of interest to note from Table 1 that on only two topics, mental illness and venereal disease, was there an average topic score of less than 38% right answers.

TABLE 1

Results on preliminary test

Topics	Average percentage of correct answers on each topic		
	Total group	Men	Women
Rheumatic fever	64.4	58.8	70.0
Nutrition	59.0	52.7	65.3
Tuberculosis	56.7	55.3	58.2
Cancer	51.4	50.5	52.3
Diabetes	50.3	45.7	55.0
Heart disease	44.7	43.3	46.0
Venereal disease	37.4	40.6	35.4
Mental health	34.9	36.0	33.8

Note 1. 59% of the entire group of 242 subjects gave correct answers to 25 or more questions on the first test.

Note 2. Average number of correct answers out of the total 50 were:

Total group	25.7
Men	24.1
Women	27.2

* The level of significance used throughout this paper is $p=<1\%$ unless otherwise stated.

The specific information and misinformation about syphilis and gonorrhea revealed on the initial test may be gleaned from Table 2.

It will be noted that there was only one question (number 8) in which there was a statistically significant difference between men and women in initial knowledge, and two (numbers 26 and 34) in which educational status proved a significant factor.

TABLE 2

Answers on venereal disease questions at preliminary test

	Statement of question	Percentage of subjects selecting each choice (correct choice indicated by underlined figures) Total	Male	Female	Education ‡ High	Low
No. 4	Syphilis sores will					
	disappear only when treated	67.5	62.0	71.0	66.0	69.0
	disappear with or without treatment	6.6	9.6	4.3	8.4	2.6
	remain about a year if untreated	2.0	3.9	0.7	1.8	2.6
	don't know	24.0	24.0	24.0	23.0	25.0
No. 8	The germs causing venereal disease					
	are very resistant to disinfectants	22.0	21.0	23.0	24.0	18.6
	die quickly outside the body	17.0	25.0*	11.5*	18.0	16.0
	live for long periods of time outside the body	17.7	15.5	19.0	18.0	17.0
	don't know	42.5	38.0	46.0	40.0	48.0
No. 10	If a syphilis sore develops on the body it					
	is always noticed by the patient	33.5	32.0	34.0	34.0	32.0
	may escape notice...	31.8	35.0	29.0	35.0	24.0
	can be seen only with special instruments	6.6	7.8	5.7	5.4	9.3
	don't know	28.0	25.0	30.0	25.0	34.0
No. 26	Gonorrhea and syphilis are					
	different stages of the same disease	19.0	12.6	23.8	18.0	21.0
	always present together in a patient	2.0	1.9	2.1	0.6	5.3
	entirely different diseases	65.0	72.0	60.0	73.0*	48.0*
	don't know	13.6	13.6	13.6	8.4	25.0
No. 34	Syphilis is usually spread from person to person through					
	direct contact	60.5	70.0	54.0	68.0*	44.0*
	instruments used in barber and beauty shops	2.0	4.8	0.0	0.6	5.3
	toilets	39.8	18.5	38.0	23.0	44.0
	don't know	7.4	6.8	7.9	7.8	6.6

Statement of question	Total	Male	Female	Education ‡ High	Education ‡ Low
	Percentage of subjects selecting each choice (correct choice indicated by underlined figures)				
No. 43 Untreated gonorrhea is frequently a cause of					
insanity	18.6	14.0	21.6	21.0	13.0
paralysis	13.6	18.5	10.0	13.8	13.0
inability to bear children	*35.0*	*34.0*	*37.0*	*36.0*	*34.6*
don't know	32.0	33.0	31.6	29.0	40.0
No. 46 A child may have syphilis because the germs pass from mother to					
her unborn child	*46.0*	*39.0*	*52.0*	*43.0*	*53.0*
the germ enters the body during the process of birth	11.5	13.6	10.0	14.0	5.3
it is inherited	23.0	25.0	21.6	24.6	20.0
don't know	19.0	12.6	16.5	18.0	21.0
Average of right answers	37.4	40.6	35.4	40.0	31.7

* The probability that the difference between these two figures is due to chance is less than 1%.

‡ High education: at least some high school.
Low education: no formal education beyond grade school.

The health educator is always eager to learn how much of the literature he distributes is read and how many facts are learned from it. Since at the time of the second test each subject of the experimental group was asked to note which of the eight pamphlets sent him he had read, an approximate answer to the first of these questions was obtained (see Table 3). The data also present some answers to the question, "What facts were learned during the course of this experiment?"

In view of the fact that only the pamphlets on venereal disease and tuberculosis were read by fewer than one-third of the experimental group, it may be of interest to record that several students noted resistance when they tried to give the pamphlet on venereal disease to their parents, particularly their fathers. Although the eight pamphlets were not of equal appeal, in our opinion the one on venereal disease was by no means the least attractive.

It will be noted from Table 3 that a statistically significant increase in score was achieved by the experimental group on the questionnaire as a whole. The control group showed no increase whatsoever. When the increased score of the experimental group was analyzed by sex, it was found that the women, who recorded reading much more of the literature than did the men, had achieved a significant increase in score whereas the men had not.

TABLE 3
Changes in score between first and second test*

Topics	Experimental group			Control group	
	Percentage who read pamphlets	Percentage of increase in right answers on each topic	p ‡	Percentage of increase in right answers on each topic	p ‡
Venereal disease	28.0	8.7	<1%	0.8	>5%
Heart disease	33.3	6.7	<1%	2.0	>5%
Diabetes	49.6	8.0	<1%	2.6	>5%
Mental health	38.8	3.5	>5%	0.6	>5%
Rheumatic fever	37.5	3.4	>5%	−3.0	>5%
Cancer	45.5	1.5	>5%	1.0	>5%
Tuberculosis	29.0	1.3	>5%	−0.7	>5%
Nutrition	35.0	1.8	>5%	−0.5	>5%

* Mean score change on the total questionnaire was as follows:

Experimental group	1.93 questions	p <1%
Control group	−0.16 questions	p >5%

‡ p refers to mean change in score on each topic.

It may also be observed that while significant score changes were made by the experimental group in three of the topics, the greatest percentage increase in right answers occurred in the case of venereal disease. In no instance was a significant increase in score made by the controls.

Table 4 presents an analysis of the changes in score made by both groups of subjects on the venereal disease series of questions.

TABLE 4
Change in score on venereal disease questions on first and second questionnaire

Question number *	Experimental group						Control group (77)	
	Total (165)		Education					
			High (120)		Low (45)			
	Increase in numbers of right answers	p	Increase in numbers of right answers	p	Increase in numbers of right answers	p	Increase in numbers of right answers	p
4	21	<1	17	<1	4	<5	4	>5
8	17	<1	13	<1	4	>5	−3	>5
10	22	<1	17	<1	5	>5	−2	>5
26	1	>5	2	>5	−1	>5	6	>5
34	21	<1	14	<1	7	<5	4	>5
43	−2	>5	−2	>5	0	>5	−6	>5
46	17	<1	16	<1	1	>5	0	>5

* For question content, see Table 2.

It is of particular interest to note that the experimental subjects exhibited a statistically significant increase in knowledge about five of the seven facts treated by the venereal disease questions. The data indicate that the level of knowledge of the more highly educated subjects was raised to a considerably greater extent than that of the less educated.

An attempt was made to determine whether there was any demonstrable difference between the experimental and control groups in their memory of other educational influences operative during the period between the initial and terminal administrations of the test. In order to elicit this information, the subjects were asked specifically about such possible media as radio, press, lectures, etc., in the case of each topic under consideration.

The experimental group recorded a considerably larger total number of such contacts with sources of information about venereal disease than the controls. The difference in recorded number of contacts between the two groups had a chance probability of less than 1%. This is of particular interest in view of the fact that there had been an intensive community-wide venereal disease campaign during the time of the experiment.

Discussion

The ultimate aim of any health education project is the translation of the knowledge gained into desirable attitudes and behavior. It is therefore the hope of the present investigators that any increase in factual information resulting from this study might be reflected in an improvement in health habits. The first step in such a campaign must be the transmission of information in a utilizable form.

Despite the fact that only 28% of the experimental group recorded reading the venereal disease pamphlet, the group as a whole achieved significant increases in score on five of the seven questions as well as on the entire series of questions about venereal disease. One may conclude, therefore, that some of the knowledge in the pamphlet is transferable to subjects who read it.

It should be noted that the more highly educated subjects (i.e., those who had had at least some high school education) achieved significant gains on four of the seven questions, whereas the less educated achieved no such highly significant gains. This suggests that this particular pamphlet is more useful for the more highly educated segment of the population, for whom it was in all likelihood designed.

Whether the observed increase in factual information would lead, for example, to a greater willingness to seek early medical attention

could not be determined under the conditions of this study. However, the finding of Wright, Sheps and Gifford * that veterans who had received venereal disease education during their Army training reported for diagnosis and treatment earlier than comparable non-veterans lends hope that the acquisition of information under the present conditions might have similar results.

Another objective of education is the awakening of interest in the subject matter and the production of a heightened awareness to other sources of information. It was gratifying to note that the members of the experimental group had been alerted to other sources, since they recalled a significantly larger number of such contacts. To what extent the observed increase in factual knowledge was directly due to information contained in the pamphlet and how much was attributable to other media in the environment is not known. It would appear, however, that the pamphlet itself acted as the primary source, both directly and indirectly.

Summary

A pamphlet on syphilis and gonorrhea was distributed to 165 parents of college students. Two months after its receipt, these experimental subjects achieved a significantly higher score on questions based upon the information it contained. A control group of 77 parents pre-tested and post-tested with the experimental group showed no increased knowledge of these facts.

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* Wright, John J., Sheps, Cecil G., and Gifford, Alice. Reports of the North Carolina Syphilis Studies: IV. Journal of Venereal Disease Information, Vol. 31, pp. 125–33 (May, 1950).

WORLD HEALTH AND TREPONEMATOSES

by Thorstein Guthe, M.D., M.P.H.

It is an unusual privilege for me to speak to such a distinguished forum of expert colleagues and specialists in the field of syphilis. Fournier's classical studies and those of Levaditi, Cougerot and other members of the distinguished French school of syphilologists have for decades contributed greatly to our basic knowledge of syphilis and have brought international reputation to French medicine. The international emphasis placed on the present symposium on syphilis, arranged by the French Health Administration in collaboration with the World Health Organization, is therefore most befitting, particularly since it has also been our privilege to obtain the assistance of colleagues and co-workers from the Americas, where new and stimulating approaches to the problem of syphilis control have originated in the last few years.

While it is our duty as physicians, investigators, workers and administrators in the disciplines constituting venereal disease control to look to the future and to the test of time for new methods to assume their rightful place in medical history, this type of international symposium in Paris, and the recent one in Helsinki, represent ways in which WHO believes that fruitful collaboration can be fostered among experts from many countries to take stock of the present situation. This gathering of highly qualified workers from 19 European countries testifies to the value attached to the free exchange of scientific information and represents a new course for research and study, the result of which WHO will watch with interest in the future.

Today syphilis is no longer a "shameful" disease. Many socially and economically developed countries are now classifying syphilis among the communicable diseases attaching little or no stigma to the mode of transmission usually recognized in western civilization. This was not so 20 to 30 years ago.

But outside Europe, North America and Australia, there are millions of peoples where a concept of syphilis as a "shameful" disease has never been recognized, where it is indeed often not associated with sexual behavior. In these areas, the acceptance and concept of syphilis remains truly an ordinary communicable disease spread by

Opening address at the International Symposium on Syphilis in Paris September 25-October 3, 1950.

direct contact, by common utensils, the common drinking cup or eating trough.

The mode of spread of the other members of the treponema family, yaws, pinta, bejel and similar "endemic" syphilitic diseases are non-venereal. In less developed areas, the treponemal diseases as a group are highly prevalent. Here lies the real problem. Considered from a global viewpoint, work in these areas must be further stimulated in the Middle East, Africa, southeast Asia, the western Pacific and South America.

It should be recognized that the incidence of early syphilitic infections alone in these areas may vary from five to 20 new cases per 1,000 inhabitants a year, and the prevalence of unclassified and latent disease may be as high as 30 to 50% on the basis of serological sampling. Furthermore, in recognizing that the prevalence of yaws in some of these areas is as high as 15 to 20% in the large population groups, such as in Indonesia and Haiti, one cannot escape the conclusion that here we find very real health problems.

How can we as physicians and collaborators in the field of health attack this problem? Surely not by visualizing some approach by mass immunization or vaccination in the unforeseeable future on the basis of the hypothesis that we shall be able to cultivate these treponemes, as has been suggested from certain quarters. However fascinating this speculation, we must use present knowledge and methods for treponematoses control in each country, whenever desirable stimulated by such support as can be given by international governmental and non-governmental organizations.

One of the objectives of the World Health Organization is "to stimulate and advance work for the control of epidemic, endemic and other diseases." In three world health assemblies convened by the 75 member nations of the organization, the justification for an active international contribution to the combating of venereal diseases and treponematoses has been emphasized by health workers. Particular stress has been placed on the damage to health of infants and the toll of all ages taken by the treponemal diseases of syphilis, yaws, pinta and bejel.

The need has been stressed for the introduction of modern methods, wherever social and economic development has been lagging. A whole series of discoveries and critical evaluations of old principles and methods in venereal disease and treponematoses control has taken place in France, Britain, the United States, the Scandinavian and other countries in recent years. These developments have given us opportunities for the future. Defensive health measures have been abandoned in favor of a more aggressive approach.

WHO team in India treats a patient.

The most significant development was the advent of penicillin preparations and cardiolipin antigens. The common vulnerability to penicillin of treponema pallidum, treponema partenue, the treponemes of bejel and pinta, the introduction of abbreviated treatments based on repository penicillin preparations have emphasized our potential to sever effectively the infectious cycle of treponemes in an epidemiologically significant manner on a mass basis. Carefully observed programs in India, Yugoslavia, Indonesia and elsewhere, supported by the World Health Organization and the UN International Children's Emergency Fund, testify to this effect. The absence of important evidence of penicillin resistance in the treponemes up to the present time underlines further the usefulness of present-day methods for treponematoses control.

Role of the World Health Organization

With this outlook, it has been the privilege of the World Health Organization to "stimulate and advance" treponematoses work on a large scale in different regions of the world.

Earlier in this address I had occasion to refer to the specific scientific aspects of this approach, which relate to the organization this year of the two international symposia on syphilis in the European area by the Health Administrations of France and Finland. However, you may wish to know a little more about the actual ways in which WHO and the UN Children's Emergency Fund are stimulating campaigns against treponemal diseases in other regions of the

world. These activities can perhaps be summarized in the following way:

Fellowships and Training Courses

Postgraduate fellowships and travel grants were awarded by the World Health Organization to nationals of a great number of countries in 1949 and 1950 for the study of the various disciplines of venereal disease control and treponematoses work. In 1949, 32 such fellowships were awarded in venereology, laboratory and other aspects.

WHO has been glad to note that among these there were several outstanding French workers who spent several months in the United States, the United Kingdom and other countries under the auspices of the French Health Administration. Many fellows have also come to France to study. The participation by France in the International Syphilis Study Commission to the United States was welcomed by the World Health Organization last year.

Training courses comprising from 10 to 15 laboratory workers at a time were organized at laboratory centers in Guatemala, Venezuela and India in 1949, and further courses are under way in 1950 and 1951 in Brazil, Thailand, Afghanistan and other countries through the cooperation of the health authorities in these countries with the WHO regional offices in the respective regions.

Advisory Services

At the request of health administrations, venereal disease control and treponematoses demonstration projects have been launched on a national scale with the support of WHO and UNICEF in Indonesia and Thailand in the Far East and in Haiti in the western hemisphere.

A large-scale bejel project is shortly getting under way in Iraq in the eastern Mediterranean area. In Indonesia and Haiti, some 150,000 cases of yaws had come under treatment up to and including September, 1950. In Indonesia, a number of native teams are operating to cover an area with several million people with an estimated 400,000 cases of yaws in the next two years. With emphasis on syphilis in pregnant women and children, venereal disease control programs are, or will shortly be under way in Egypt, Burma and India.

WHO furnishes a nucleus of international advisers for these projects, the international personnel being withdrawn following an initial "demonstration" period of a year or more so as to insure the carrying forward of these programs by the health administrations concerned. UNICEF in many instances furnishes basic supplies and equipment in this initial period, valued at several million dollars.

WHO and venereal disease treponematoses advisers are attached to the regional offices of the World Health Organization in Europe, the eastern Mediterranean, southeast Asia and the western hemisphere to insure coordination of the work.

WHO Expert Committees and Research

To advise the World Health Organization, an expert committee on venereal infections and treponematoses has been established. Three sessions have been held by this committee. A special subcommittee on serology and laboratory aspects has also been constituted. The reports of these committees, which have guided the development of the WHO program, are available to the participants of this symposium.

WHO has been privileged to be guided by the wisdom of the elected chairman of the main expert committee, Dr. John Mahoney, who is known to all of us as the original discoverer of penicillin as an effective treponemicidal antibiotic in syphilis in 1943.

Recent scientific advances, notably the identification of treponemal antibodies and the immobilization technique of Turner and Nelson, permit substantial quantities of relatively pure treponemata to be isolated for the study of the biological and immunological relationships between the causative agent of sporadic and endemic syphilis, yaws, bejel and pinta in men and animals. The opportunity has arisen with the several treponematoses projects in various parts of the world for a comparative study of the treponema relationships, aiming at a contribution to our knowledge on, the definition of the nature of, treponemal diseases as a group. This international treponematoses study was started in 1950 under the guidance of the expert committees. A central guiding laboratory has been selected to carry this research forward, the department of bacteriology of the Johns Hopkins School of Hygiene and Public Health under the leadership of Dr. T. Turner.

Other laboratory activities for the evaluation and standardization of sero-tests in syphilis are under way, aiming at the organization of an international serodiagnostic laboratory conference in 1951, patterned on the laboratory conferences of the health section of the League of Nations.

Permit me finally to say how much the staff of the venereal disease and treponematoses section of WHO has appreciated the privilege of assisting in this symposium. I hope that the scientific discussions over the next two weeks will move forward in the spirit of international collaboration to which all individual workers here gathered are able to contribute so much. This is the type of collaboration and free exchange of scientific information which we need in our troubled times.

BOOK NOTES

The Challenge of Delinquency, by Negley K. Teeters and John O. Reinemann. New York, Prentice-Hall, Inc., 1950. 819p. $7.35.

Dr. Teeters, professor of sociology at Temple University, and Dr. Reinemann, Philadelphia probation director, make an effective combination in authoring this college textbook on the causes and control of delinquency as a national problem.

Part one covers the scope of the problem: the confusion about definition, causes and prevalence; a history of concepts and salvaging devices from ancient times until the present era; the biological approach; nationality, socio-economic and cultural factors; and the psychiatric approach. Our materialistic philosophy with its attendant corruption in government, police and political spheres has a share of the responsibility.

Out of this welter of causes, the authors emerge with the conclusion that "A delinquency or crime is committed only when just the correct combination of personal and social factors come into existence to create a specified delinquent situation." One may not agree with the authors about this inevitability in a given situation, but one will agree with them that a given set of factors will not necessarily produce a delinquent act, as social situations may be only apparently similar and no two individuals are alike. In short, there is no royal road to solving the riddle, although certain conditions are more favorable to delinquency than others.

The second part discusses the control and treatment of juvenile delinquency. Of particular interest to social hygiene workers is the chapter on "The Young Sex Delinquent," which considers prostitution as a social problem and stresses preventive measures.

Part III, on community responsibility, covers the preventive services of the police, school, clinic, social group work, social case work and the church; social action, both governmental and citizen; and interpretation, which examines the various media available for educating the public to the realization that the treatment approach is the more effective method of dealing with delinquency.

A comprehensive appendix of case histories, bibliography, and name and subject indices completes a volume of undoubted interest to sociologists and youth leaders.

Working with Teen-Age Gangs. A Report on the Central Harlem Street Clubs Project, by Paul L. Crawford and others. New York, Welfare Council of New York City, 1950. 162p. $2.75.

The experimental project described in this report studies the problem of street gangs in Central

Harlem and formulates a program of action to test whether the street club can be influenced toward socially desirable behavior.

Punishment and existing recreational facilities were not doing the job. Perhaps if the adolescent gang member were approached in the right way by the right type of adult, he could be given a sense of community responsibility and emotional security. Area projects were organized around a local committee with professional workers.

To some of the boys, parents were merely authorities who pushed them around. The boys retaliated by staying away from home for days.

Since each street club had a group of girls associated with it, a woman area worker was appointed to handle the girls. Most of the girls were sexually promiscuous, with illegitimate pregnancies common.

Sex offenses occurred very rarely, although the boys saw nothing wrong in forcing a girl into sexual relations, and most of them were contemptuous toward girls.

At the end of the project, the boys showed a much better attitude toward girls and sex offenses.

The report is valuable in that it gives specific information about how workers won over some of the boys; shows how they encouraged self-direction in the clubs; furnishes a guide to other groups working with street gangs; evaluates the project's accomplishment; and discusses the personality traits desirable in a worker with gangs.

Current Therapy, edited by Howard F. Conn, M.D., and 12 consultants. Philadelphia, W. B. Saunders Company, 1951. 699p. $10.00.

The first edition of this book, published in 1950, was such a success that a new and enlarged edition has now been issued. It is the work of the above-mentioned editor and consultants and 275 contributors. It deals with therapy only.

The first part of the book describes the therapies of infectious diseases with the notable exception of tuberculosis and all of the venereal diseases. Following this section, therapy is discussed by the systems affected, as, for example, the cardiovascular system, genitourinary system. The venereal diseases are discussed as a group as are also allergic diseases.

Dr. Robert B. Greenblatt, of the University of Georgia, describes the therapies of the so-called "minor venereal diseases"—chancroid, granuloma inguinale and lymphogranuloma venereum. Dr. Paul R. Leberman, of the University of Pennsylvania, describes the therapy of gonorrhea. Five different authors discuss the treatment of syphilis in its several stages. The contributors to the section on syphilis are:

Dr. William Liefer—New York University
Dr. Roger J. Burkhart—Veterans Hospital, San Jose, Calif.
Dr. Arthur C. Curtis—University of Michigan
Dr. Edgar B. Johnwick—United States Public Health Service
Dr. Loren W. Shaffer—Wayne University
Dr. Bernhard Dattner—New York University
Dr. Robert R. Kierland—Mayo Clinic

The therapies described are in every case the currently accepted methods, but in some instances more than one method of therapy is presented, indicating some differences of opinion among the authors.

The discussions of treatment are brief but probably sufficient for the needs of general practitioners for whom this book is intended. *Current Therapy* should prove a very useful reference work for busy physicians who cannot read the longer and more complete books.

CHARLES WALTER CLARKE, M.D.

Practical Statistics in Health and Medical Work, by Ruth Rice Puffer. New York, McGraw-Hill, 1950. 238p. $3.75.

Developed from ten lectures in practical statistics with examples from Tennessee health programs, this book shows health workers and statisticians how to use data to define problems, how to develop records and procedures for administration and analysis and how to evaluate and improve a program.

Elementary enough to appeal to the beginner, the book—with its examples of incidence and prevalence formulas, punch cards, tables and graphs, and formulas for figuring rates, as for instance, morbidity rates—has much practical information for the statistician.

There is an interesting section which shows how results of serologic tests for syphilis in Selective Service were analyzed to reveal areas in Tennessee of high syphilis prevalence and to indicate a proper allocation of VD funds.

Child Psychiatry in the Community, by Harold A. Greenberg, M.D., and others. New York. G. P. Putnam's Sons, 1950. 296p. $3.50.

This is an outline of current thinking as developed by means of work in a child guidance clinic, the operations of which are presented to help nurses, teachers and others understand the purposes of such a clinic. Thus it is hoped that they will then urge parents and children to seek out psychiatric and clinical services.

The first part concerns the child, his developmental stages, his problems, their causes, diagnosis and treatment; the second, the functions of various clinical workers; and the third, the relation of the clinic to the community.

BEHIND THE BY-LINES

Major General John M. Devine

General Devine is the man who organized and commanded the universal military training experimental unit at Fort Knox soon after the war. Now he is chief of the Armed Forces' information and education division. Between the two wars, during which he led troops in Europe (and for a time was General Patton's chief of staff), he was on the faculties of the field artillery school at Fort Sill, the United States Military Academy and Yale University.

Judson T. Landis

Dr. Landis, who is associate professor of family sociology, joined the University of California faculty last year to organize courses in marriage and family relations. With his wife he has written several books on marriage and family life. He says that their children, Judson, 15, and Janet, 12, "do their best to keep us on the beam. They were good critics as we worked on our newest book, *Personal Adjustment, Marriage and Family Living*, used with teen-agers in high schools."

G. G. Wetherill, M.D.

A specialist in pediatrics and education, Dr. Wetherill has been director of health education for the San Diego City Schools since 1935. He is the author of a college textbook on hygiene, of many professional articles, of one of ASHA's most popular publications, *Human Relations Education*, which he has just revised, and of a brand-new series of recordings on sex education for family use. His hobby is his family, with woodworking in second place.

Bruno Gebhard, M.D.

Dr. Gebhard has been director of the Cleveland Health Museum since 1940. Before that, he had been curator of the German Hygiene Museum in Dresden and technical consultant on medical and public health exhibits for the New York World's Fair. He was editor and author of *Wonder of Life* and *The Life of Woman in Health and Disease.* Dr. Gebhard, who became an American citizen in 1944, is an associate in health education in Western Reserve University's School of Medicine.

Thorstein Guthe, M.D.

Dr. Guthe, chief of the World Health Organization's venereal disease section, studied in England, France and the United States as well as in his native Norway. Early in the war he was in charge of VD control for the Norwegian Overseas Air Force and later VD control officer in charge of Norwegian overseas public health clinics for maritime personnel. Later he was assistant to Norway's Surgeon General of Public Health and in 1944 was a member of UNRRA's standing technical committee on health.

Beatrice G. Konheim
Dorothy N. Naiman

Both Dr. Konheim and Dr. Naiman are assistant professors in Hunter College's department of physiology, health and hygiene. Both received their Ph.D.'s from Columbia University, Dr. Konheim in physiology, Dr. Naiman for work in bacteriology in the College of Physicians and Surgeons. Both are interested in community health activities. Dr. Konheim lectures on sex hygiene for the social hygiene committee of the New York Tuberculosis and Health Association, Dr. Naiman is active in the PTA. And both are mothers of youngsters just entering their teens.

THE LAST WORD

Shall We Change the Date?

Because the weather in early February frequently conspires against National Social Hygiene Day, many of you have suggested that we change the date of the annual observance.

The bad weather speaks for itself. In addition, some local affiliates have pointed out that the present early-February observance of Social Hygiene Day cuts into the heart of projects scheduled in the nine or ten months between the opening of schools in the fall and the summer vacation period.

Tentative proposals call for the shifting of Social Hygiene Day to the first Wednesday in May, when the observance would very naturally bring your work to a satisfyingly dramatic climax in which your whole community could participate.

How does this plan sound to you? What advantages do you see? What disadvantages?

We need your suggestions and recommendations and the value of your experience in planning local Social Hygiene Day observances. We cannot make a change effective without your *active* cooperation. May we hear from you soon?

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ASHA's Job in National Defense

- ★ To study prostitution conditions, particularly near military installations and industrial centers
- ★ To prepare fully documented reports on local prostitution conditions for the information and guidance of military and civil authorities
- ★ To provide community leaders with the facts about the dangers of commercialized prostitution
- ★ To advise communities on the most effective ways of repressing vice and to recommend ways of treating sexual delinquents
- ★ To stimulate adequate wholesome recreation as a morale-building safeguard against sexual misconduct
- ★ To intensify the spread of sound information about venereal disease, particularly to young people entering the Armed Forces
- ★ To help strengthen family life against the tensions of the times by fighting VD and sexual promiscuity, two major threats to family health and well-being
- ★ To encourage education for family life, through publications, study courses for parents, and formal training for teachers, youth leaders and others who influence young people

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